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Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

The Changing Face of Children's Health:

Results from the National Survey of Children's Health

Q&A

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GOPAL SINGH: The answer to that is no. The differences get reduced to some extent but those differences remain very marked and in one of the papers I published two months ago in the January issue of (Inaudible) Epidemiology, we have extensive data on changes of ethnic disparities or social disparities over time but that's one of the things we do talk about. So, although the ethnic patterns in obesity or overweight do not change even after you control for social and economic differences or household characteristics or differences with respect to neighborhood conditions but they do explain some of the (inaudible). So, non-Hispanic black children or Hispanic children or Hawaiian-Pacific Island children would have two to four times higher odds of being obese or overweight then say Asian children and non-Hispanic white children. So, the differences are greater if you did not. Like the observed differences are much greater then what you would find if you were to control for these differences. I believe you had a question too.

QUESTION: (Inaudible)

REEM GHANDOUR: Let me make sure I'm understanding. So you were wondering about the state picture in terms of primary care provider availability and how that might affect diagnosis. Actually, I would really like to look at that particularly in terms of the differences for behavioral conditions versus the emotional conditions because at least from what I've read it does seem like primary care doctors or pediatricians are much more comfortable with some of the behavioral conditions or at least those are the things that our parents are coming in and saying, I want you to help me figure out what's happening. It's an important next step. I haven't quite gotten into that yet. I'm still trying to figure out what we can do. I'm really interested in looking at some of the policy level differences that are happening at the state level. So, I feel like there's a whole lot of different directions we could go in this and I was just thinking while you were asking that one of the things I really wanted to do with this analysis was to kind of get us passed this idea that it's all the child level or family level factors. There's a whole other level that we can really be thinking about in terms of identifying kids and getting them into the services they need and that's where I was trying to go but I feel like you've raised this point where once we take it beyond the child level there are so many other places we can go with it. So, I've a lot of work to do but thank you for raising that.

QUESTION: (Inaudible)

REEM GHANDOUR: It sounds like you're touching on a really important point about, it's kind of a larger question about what happens to these kids once we diagnose them and who ends up getting diagnosed and what groups of kids do we automatically assume should be screened or not screened and I think it's a little bit, if I can respond to that, I think it's a little bit of a double-edged sword too because we really do want to get kids into treatment if they need it and in some senses identifying a child whose mother is in poor mental health may help us know that we need to maybe screen a little more rigorously in that family. I think there's challenges there and there are also challenges given the stigma associated with a mental health diagnosis and what it does to kids. So, I think we all are thinking about this very carefully but you raise a really good point.

QUESTION: (Inaudible)

REEM GHANDOUR: The question was about prevalence of ADHD. I can't tell you offhand today but I can certainly follow-up with you afterwards.

MICHAEL KOGAN: I think it's around 8%.

QUESTION: (Inaudible)

REEM GHANDOUR: Your point is actually really well taken that the observed decrease in the diagnosis of oppositional define and conduct disorder may reflect better diagnoses of other types of developmental and behavioral conditions.

QUESTION: (Inaudible)

REEM GHANDOUR: The first question if I heard you correctly was have we considered access to care issues in looking at state level differences? Very crudely I tried to get into that by getting a handle on or trying desperately to get a handle on parody laws. I was wondering if states that had enacted in some senses a lot like Jess had looked at the legislation that was out there. What I discovered is that every state has done it just a little bit differently. So, I felt very in some ways ill-equipped to get into that but I did at least find one analysis that had been done by I believe it was the National Governor's Association that very nicely kind of lumped states into parody, some form of equal access and then nothing. When I looked at the states that were designated as having some form of parody law those really did cluster in the northeast, which is also where I saw the highest prevalence of the emotional disorders and given that those are the ones that the depression and the anxiety are less likely to be diagnosed in a primary care setting, what I read into that was that these are states that had made access to mental health professionals in particular maybe just a little bit easier for families and so kids were able to get from the primary care setting into a specialist to get that kind of a diagnosis. That might be a reach but that's kind of what I think is happening but I think you're right looking at the number of perhaps pediatric mental health specialists might be another way to go at this and try to get at the access issue.

In terms of your second question about the correlation with suicide rates I haven't looked at that yet but that's a really good suggestion. I've definitely noted that. Thank you.

QUESTION: (Inaudible)

GOPAL SINGH: I think what she's trying to ask is whether there is a geographic association between the patterns that you see with respect to breastfeeding and early childhood obesity rates. Yes. When I saw Jessica's slides some of the states that have very low rates of breastfeeding initiations are the ones that have fairly high rates of obesity. They actually rank at the top. These would be West Virginia, Louisiana, Mississippi and some of the states in the northwest such as Oregon and Washington. They have very low rates of childhood obesity. So, there seems to be a connection there but in the (inaudible) level research this has been mixed but I think most studies have shown an association between high rates of breastfeeding and lower risk of obesity. So, there's more studies pointing to that then studies not showing a significant association between the two, even the (inaudible) studies too. So, there seems to be a fairly interesting connection at least at the state level that is what we see.

JESSICA JONES: Karen, you are asking specifically about early, young childhood obesity?

QUESTION: (Inaudible)

JESSICA JONES: Among all children?

QUESTION: (Inaudible)

JESSICA JONES: The problem that we have with that particular survey is we don't calculate overweight and obesity for those under five or actually for those under eleven. So, we're not able to look at it of that age group of the same age group that we ask the breastfeeding questions and basically track the breastfeeding progress. We're not able to look at overweight and obesity because studies have shown as the child's age goes up the parent's ability to adequately report their height and weight also increases and on the younger kids it's unreliable data. So, we don't look at it.

JESSICA SINGH: We did look at it. There is something that is very similar to what you see. The children six to nine where we see these overweight problems. (Inaudible) for children 10 to 17 and look at older adolescents but we do have confidential data for children under eleven and from six to eleven. Those patterns very much coincide with the breastfeeding patterns that you see. An interesting question actually came to me as well when I was watching Jessica's slides because what would it be like if you had to relate the 2003 patterns with the 2007 obesity rates for children six to ten five years on? You would probably see a fairly strong cessation especially on the state level but that's something that we will look into.

QUESTION: (Inaudible)

GOPAL SINGH: Obesity rates? I think it was for Oregon if I remember.

MICHAEL KOGAN: So, you want to know why Oregon went down 32% in terms of childhood obesity and what some of the reasons might be.

GOPAL SINGH: Yes, it was Oregon that went down 32% and because we did not do a state specific analysis like focusing specifically on Oregon we didn't even look at some of the population level factors that we talked about might be contributing to the changes in obesity rates between 2003 and 2007. For example whether there has been a change in terms of the socioeconomic composition for the state or other dietary factors changing over time or have the physical activity rates for children changed over time? Those are some of the things that we will have to look at for the state of Oregon to be able to say that those are the factors responsible for the decline in child obesity but yes that is a very good question. I think we will have to carry out state specific analyses like for a particular state. Maybe that's something that people from those states can take on those analyses.

QUESTION: (Inaudible)

MICHAEL KOGAN: Your question was if I can paraphrase it, in the future if we do sampling from cell phone numbers do we expect it to be any different? The answer is

yes. It could be different in a number of ways. We know that people who use cell phone only tend to be younger. We know that they are more mobile. They are less likely to own homes. So, it's somewhat of a different population. We also know that they're harder to reach and so it will affect the survey in a few ways. One is unfortunately it will make it more costly because there is no list of cell phone numbers that we found to be reliable. We thought we had some and that has not turned out to be the case. People are sometimes leery about answering their cell phones with a number they don't recognize because if they are charged minutes they don't want to pick it up and so we're going to experiment with that. We're going to experiment with an address pay sample. Then, we're faced with the issue of adjustments afterwards. There are cell phone number lists in development and we're hoping that by the time the next survey is completed, which is the National Children's Special Healthcare Needs survey more or less at the end of this year that we will have some framework that we can adjust it to, to make it nationally represented.

Any other questions?

QUESTION: (Inaudible)

REEM GHANDOUR: The question was about whether or not stratification occurred in the analysis for emotional and behavioral symptoms and whether or not the stratification was by age group and I did not actually do that and that's actually a really good point. I think it's probably the next step. I want to go back and look at some of the more

traditional socio-demographic characteristics and kind of parse those out a little bit more.

QUESTION: (Inaudible)

JESSICA JONES: The question was about FAS and whether that is in the survey and it is not.

MICHAEL KOGAN: Other questions? Well, this has certainly been a questioning audience. Thank you for all your questions. Thank you for attending this session. We really appreciate it. Please fill-out your evaluation forms and once more join me in thanking our three speakers.

(Applause)